OMB No. 0938-1378 Expires: 7/31/2024

SummaCare℠
Health Insurance

2023 Medicare Advantage Plan

Individual Enrollment Request Form

Who can use this form?

People with Medicare who want to join a Medicare Advantage Prescription Drug Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15 – December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must receive your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
SummaCare
ATTN: Medicare
PO Box 3620
Akron, OH 44398-0998

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call SummaCare at **888.464.8440.**
TTY users can call **800.750.0750**. Or, call Medicare at 1.800.MEDICARE (1.800.633.4227). TTY users can call 1.877.486.2048.

Llame a SummaCare al **888.464.8440 (TTY 800.750.0750)** o a Medicare gratis al 1.800.633.4227 y oprima el 2 para asistencia enespañol y un representante estará disponible paraasistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g. social security checks) may be considered your permanent residence address.

Section 1: All fields in Section 1 are required (unless marked optional)

Select the plan you want to join:
Please ensure the plan you are enrolling in is available in the county in which you reside.

O Amber (HMO) $0/month

Optional Supplemental Dental: Please indicate whether you'd like to enroll in the optional supplemental dental plan.

O **YES,** I would like to enroll in the optional supplemental dental plan. **I understand that I will be billed an additional $35 each month for this coverage.**

O **NO,** I do not want to enroll in the optional supplemental dental plan.

Effective Date: The date you want coverage to begin. In general, requests to enroll will become effective on the first day of the month after this form is received. (Month)_____ (Year) 2023

First Name: _____ Last Name: _____ Middle Initial (Optional): ___

Birth Date (MM/DD/YYYY):_____ Sex: **O** M **O** F Phone Number: _____

Permanent Residence Street Address (Don't enter a PO Box):

Street Address: _____

City: _____ County: _____ State: Ohio Zip Code: _____

Mailing Address, if different from your permanent address (PO Box allowed):

Street Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Email Address (Optional): _____

Your Medicare Number:_____

Answer These Important Questions

Some individuals may have other medical or drug coverage including private insurance, TRICARE, Federal employee health benefits coverage, VA benefits coverage or State pharmaceutical assistance programs. Will you have other medical or prescription drug coverage in addition to SummaCare? O Yes O No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage.
Please indicate other <u>medical</u> coverage information:
Name of other medical coverage: _____
ID # for other medical coverage: _____
Group # for other medical coverage: _____
Start and end dates for other medical coverage:_____

Please indicate other <u>prescription drug</u> coverage information:
Name of other prescription drug coverage: _____
ID # for other prescription drug coverage: _____
Group # for other prescription drug coverage: _____
Start and end dates for other prescription drug coverage:_____

IMPORTANT: Read and Sign Below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in SummaCare.
- By joining this Medicare Advantage Prescription Drug Plan, I acknowledge that SummaCare will share my information with Medicare, who may use it to track my enrollment, to make payments and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my SummaCare coverage begins, I must get all of my medical and prescription drug benefits from SummaCare. Benefits and services provided by SummaCare and contained in my SummaCare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor SummaCare will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that: 1) This person is authorized under State law to complete this enrollment and 2) Documentation of this authority is available upon request by Medicare.

Signature: _____ **Today's Date:** _____

If you are the authorized representative, sign above and fill out these fields:

Name: _____

Address: _____

Phone Number: _____ Relationship to Enrollee: _____

Section 2: All fields in Section 2 are optional.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a or Spanish origin? Select all that apply. (Optional)

O **NO,** not of Hispanic, Latino/a, or Spanish origin
O **YES,** Puerto Rican
O **YES,** Mexican, Mexican American, Chicano/a
O **I choose not to answer**
O **YES,** another Hispanic, Latino/a, or Spanish origin

What's your race? Select all that apply. (Optional)

O American Indian or Alaska Native
O Asian Indian
O Black or African American
O Chinese
O Filipino
O Guamanian or Chamorro
O Japanese
O Korean
O Native Hawaiian
O Other Asian
O Other Pacific Islander
O Samoan
O Vietnamese
O White
O **I choose not to answer**

Section 2: Continued

List your Primary Care Provider (PCP), clinic or health center

PCP Name: _____

PCP Code:_____ (this can be found in the provider directory)

Do you want to receive certain SummaCare information electronically? O Yes O No
If yes, please indicate the materials you want to receive electronically (you will receive information on how to access these documents upon enrollment):

O Explanation of Benefits (EOB) documents O Premium invoices (if applicable)
O New member materials including your Evidence of Coverage document

Do you want us to send you information in a language other than English? O Yes O No

Select one if you want us to send you information in a language other than English.

O Spanish O Chinese O German O Arabic O Pennsylvania Dutch
O Russian O French O Vietnamese O Cushite/Oromo O Korean
O Italian O Japanese O Dutch O Ukrainian O Romanian O Nepali

Select one if you want us to send you information in an accessible format.

O Braille O Large Print O Audio CD

Please contact SummaCare at **888.464.8440** if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week, from October 1 through March 31 and 8 a.m. to 8 p.m., Monday - Friday, from April 1 through September 30. TTY users should call **800.750.0750**.

Do you work? O Yes O No

Does your spouse work? O Yes O No

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) using one of the following payment methods below.

If you do not select a payment option, we will mail you a bill each month.

O Get a monthly bill in the mail.

O Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

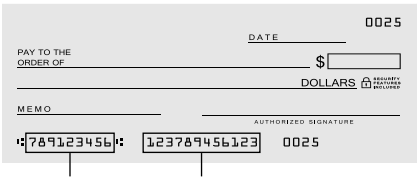
Account Holder Name: _____

Banking Routing Number: _____

Bank Account Number: _____

Account Type: **O** Checking **O** Savings

U.S. Checks



Bank Routing Number

Bank Account Number

O Credit Card. Electronic charges to your VISA, MasterCard or Discover each month. Please provide the following information:

Type of Card: **O** VISA **O** MasterCard **O** Discover

Name of Account Holder as it appears on card: _____

16-digit Credit Card Number: _____

CVV Number (3-digit code on back of card): _____ Expiration Date (MM/YY): _____

O Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check*

I get monthly benefits from: **O** Social Security **O** Railroad Retirement Board

PLEASE NOTE: The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, the effective date of the deduction will NOT be the same as your enrollment effective date with SummaCare. SummaCare will send you a monthly bill in the mail until we receive notification from Medicare as to which month they begin taking the money out of your Social Security check. You are responsible for paying by check until such time as we have established the effective date of your withhold.

*You should know that Social Security LIMITS the automatic deduction amount allowed from your benefit check to $300. For example, should you select the SummaCare Medicare Emerald plan and there is a two-month delay in processing, the entire transaction will be rejected by Social Security because the deduction amount would exceed $300. You will then default back to being billed by mail for all unpaid premiums.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit or you may get a bill from Medicare (or the RRB). DON'T pay SummaCare the Part D-IRMAA.

Office Use Only:

Signature of staff member/agent/broker (if assisted in enrollment):

Broker Code: _____ Date Form Received: _____

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

- **O** I am new to Medicare.
- **O** I am enrolling during the Annual Enrollment Period from October 15 to December 7.
- **O** I have had Medicare prior to now, but am just turning age 65.
- **O** I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- **O** I am joining a 5-Star plan during the Special Election Period from December 8 to November 30.
- **O** I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date): _____.
- **O** I recently was released from incarceration. I was released on (insert date): _____.
- **O** I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date): _____.
- **O** I recently obtained lawful presence status in the United States. I got this status on (insert date): _____.
- **O** I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance or lost Medicare) on (insert date): _____.
- **O** I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help or lost Extra Help) on (insert date): _____.
- **O** I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- **O** I am moving into, live in or recently moved out of a long-term care facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date): _____.
- **O** I recently left a PACE program on (insert date): _____.
- **O** I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date): _____.
- **O** I am leaving employer or union coverage on (insert date): _____.
- **O** I belong to a pharmacy assistance program provided by my state.
- **O** My plan is ending its contract with Medicare or Medicare is ending its contract with my plan.
- **O** I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date): _____.
- **O** I was enrolled in a Special Needs Plan (SNP), but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date): _____.
- **O** I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity). One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact SummaCare at **888.464.8440** (TTY users should call **800.750.0750**) to see if you are eligible to enroll. We are open 8 a.m. until 8 p.m., seven days a week, from October 1 through March 31 and 8 a.m. until 8 p.m., Monday - Friday, from April 1 through September 30. SummaCare is an HMO and HMO-POS plan with a Medicare contract. Enrollment in SummaCare depends on contract renewal. Every year Medicare evaluates plans based on a 5-star rating system. H3660_23_410_C Approved 08232022